Frequently Asked Questions & Answers
Community Service Providers in the I/DD system

Updated 9.12.13

1. **Who will we send our prior authorizations (PA's) to after January?**

   The MCOs will authorize services effective January 1, 2014

2. **If community service providers (CSP) have 30 days to bill a service, how do we back bill services since most plans of care (POCs) take the State sometimes over 30 days to approve? What if the service is billed, but due to the Managed Care Organization (MCO) denial it is pushed out of the 30-day window before the provider can rectify the issue with the claim? How is that handled?**

   Your contract with the managed care company will dictate how much time you have to bill for services. It is typically 90 to 180 days.

3. **Can we negotiate in the contract, for providers to be paid in seven days instead of thirty days, as this is the current Kansas Medicaid standard for turnaround time?**

   The MCOs will pay you as quickly as possible. They are contractually required by the State to pay within 30 days, but have a pay-for-performance measure where they can earn additional dollars if they pay claims within 20 days. Some have instituted their own internal expectations to pay claims within 14 days.

4. **Can we negotiate the 180- or 90-day termination time in the contract?**

   You can discuss this with the MCOs but generally they need as much notice as possible to ensure their members get placed in appropriate services.

5. **Are case managers going to be impacted by the Health Homes?**

   The Health Homes project is in process of being implemented. If an I/DD member is in a health home, then yes, providers would be impacted. We recommend you keep tabs on the KanCare website Health Homes page to stay informed of this fast paced project. http://www.kancare.ks.gov/health_home.htm

6. **Would you advise using a Clearing House to expedite our claims?**

   The MCOs recommend using their own portals to do billing.

7. **The MCOs have had since January to figure out billing but so far, have not. How can we expect them to have it fixed by January 2013? There are constant issues with delay in payment and systemic denials.**

   Most providers are getting paid timely. Getting your contract done as early as possible and attending all trainings available on the billing process will help ensure you are able to make this transition as smoothly as possible. Please ask for help if you need it.

8. **Are the MCOs allowed to pay us reduced rates with the remaining pay contingent upon audits?**

   No.

9. **We have heard that MCOs will only pay 90% of claims and then not pay the rest until they audit you. Then, if there are issues with the audit, they don't pay the other 10%. Is this true?**

   No.

10. **What are the MCOs doing to reduce errors on claims - specifically saying a claim is not "clean" and requesting information that was actually already sent?**

    MCOs are continually training their staff to help ensure claims are paid correctly. Recommend you get to know your provider representative in your area for each MCO to get help with ensuring you are submitting claims without errors. Information available at each MCO website for this:

    Sunflower: http://www.sunflowerstatehealth.com/files/2012/06/SSHP-KS_PRMap_071113.pdf?55255d

    United: http://www.uhccommunityplan.com/assets/KS-HCBS-TerritoryMap.pdf

    Amerigroup: https://providers.amerigroup.com/Documents/KSKS_ProviderReps.pdf

11. **What happens if KDADS stops publishing tier rates with the contracts saying they will pay 100% of published rates? If rates are no longer published, then what?**

    KDADS will continue to be responsible for tier rates.

12. **How will the MCOs pay out on Super tier rate clients? Will the MCOs pay at the current published rates?**

    KDADS will convey this information to the MCOs so they can pay the appropriate rates

13. **What is the truth about case management? Is it staying or going?**

    Targeted Case Management will continue after January 1, 2014.

14. **Should we expect an audit, and if so, how should we prepare? What will you be auditing and why? Please be specific in regards to Day/Res vs. TCM.**

    The MCOs may request to see your records for a variety of reasons. Please continue to document your services as you are currently doing and be prepared to make records available on an as requested basis.

15. **Does billing for 2013 on KMAP expire on December 31, 2013? If so, how will providers bill for December and how will we back bill any services after 12/31/13 if a POC is not approved yet or we have denied claims in the KMAP system for prior dates of service?**

    All billing for dates of service before January 1, 2014, should continue to be billed through KMAP.

16. **Are our TCM/ Residential/Day Supports reimbursable rates negotiable?**

    While rates are technically negotiable with the MCOs, they cannot pay below the current Medicaid rates.

17. **Is the case note system going to be revised to resemble the medical model, or is our current case note system adequate?**

    You may use whatever case note system you like to document services as long as current documentation requirements are followed and you are able to produce documentation requested by the MCOs.

18. **Are TCM's going to be expected to transition our case note log to the BCI system for uniformity?**

    No.

19. **Are the MCOs going to have their own case note/log system for CPS to use for all services?**

    No.

20. **What are the MCOs expectation/standards of daily log notes for Day/Residential providers? If they do audit files, what are they looking for to establish the services were received?**

    The MCOs each have a provider manual with documentation guidelines, your current documentation requirements should work fine.

21. **Is Therap an option w/the MCOs for use of pertinent documents relating to the I/DD Waiver?**

    Yes. Please see the answer to question number 17.

22. Is our 2010 CDDO affiliate agreement still valid as we have not signed an affiliate agreement in 3yrs and it is requested for contract with MCOs?

During the contracting and credentialing with the MCOs, you will be expected to include all your affiliate agreements as part of that process.

23. How does our 2010 affiliate agreement affect our ability to contract w/MCOs, and how does this affect the language of the HB2155 which states that the MCOs only have to contract with at least 2 providers serving each county?

The "two providers per county" language in the house bill is intended to be a minimum threshold. The MCOs are to contract with all current providers.

24. What is the status of the I/DD Pilot Program w/regards to test billing?

Daily test billing started the week of September 16, 2013, with live billing starting on October 1, 2013.

25. Are each MCOs establishing their own billing methodology, and if so what is it? Span, or daily billing?

Yes, each MCO will have their own billing methodology but you may use span, or daily or weekly or whatever frequency you like for billing with each MCO

26. Do the MCOs intend to move Day Support services to 1 unit = 15 minute billing status?

The State, in conjunction with the MCOs, is moving to a 1 unit = 15 minute billing effective January 1, 2014. The State will provide training and information for this change.

27. What can be done to ensure all MCOs will offer span billing (billing over a period of time, such as a week or a month, instead of billing daily) for the I/DD waiver? As we understand one of the MCOs is not offering span billing.

The MCOs are offering span billing.

28. Are the MCOs prepared to changed reimbursement rates based on tiers and will those changes in reimbursement be made in a timely manner (please define "timely" if so).

We are working through this currently in our implementation process. The MCOs will get this information from the State to ensure they can process claims timely.